involved 40 women aged 28 to 60 who had mild to moderate photo-related facial damage. On the basis of clinical evaluations, computerized image analysis of silicone imprint samples of the skin and patient self-appraisal, results were essentially the same. In a small number of cases results were deemed to be excellent; most felt they got moderate improvement, although some patients "felt there weren't any changes at all."

Shalita suggested the 10% concentration of tretinoin used initially by the University of Michigan researchers is not advisable initially for anything other than possibly hypertrophic scars.

Shalita said tretinoin does certain things quite well but it is only one aspect of the total spectrum of treatment for photoaged skin, which includes injection of filling material, chemical peels and reconstructive surgery. "What's really important for everyone to understand is that topical tretinoin is really only entry-level treatment."■

Prevention through partnership theme of Ottawa workshop

Peter P. Morgan, MD, DPH

No group acting alone, including the medical profession, can do much about the really tough challenges in disease prevention, planners and participants attending a recent workshop in Ottawa concluded. Instead, collaboration is the key word.

Irving Rootman, director of the Centre for Health Promotion in the University of Toronto's Division of Community Health, carefully dissected out the meaning of prevention before the participants were turned loose in workshop sessions. There they planned health promotion projects that could succeed only by bringing together diverse resources in a common cause.

It seems there are numerous "C" words other than collaboration: coordination, for instance, or cooperation, coalition, communication, collective action, even complementarity.

However, collaboration "requires a greater degree of commitment of resources and attention than do other forms of working together," Rootman said. It means the coming together of parties — "stakeholders" — each of which recognizes one aspect of a problem and has something to contribute to the solution.

The workshop itself was a form of collaboration because it was sponsored jointly by the CMA, Department of National Health and Welfare, Canadian Nurses Association, Canadian Dietetic Association and Canadian Public Health Association.

Why would people want to collaborate over health promotion? Typical motivations are the need to resolve conflict, to work for the collective good, or to use scarce resources more efficiently. For example, a well-established program in Calgary unites the health care, education and social service fields in a program involving teachers, nutritionists and community health nurses. Its goal is to create a healthy prenatal and postnatal environment for the children of young mothers, while at the same time allowing the mothers to finish school.

Health is a unifying social concern. The common commitment to prevention among the workshop's 70 participants kept them working well together, and their diversity of backgrounds added a sense of adventure. Of course, a spirit of collaboration lingers in the Government Conference Centre where the workshop was held; many major national conferences are held here.

Following the pattern of the previous conference, Enhancing the Provision of Preventive Services by Canadian Physicians (*Can Med Assoc J* 1990; 142: 1113-1117), participants were assigned to workshops according to their regional affiliations.

Some chose concrete objectives such as weight control in children or the prevention of gasoline sniffing; others attacked more complex problems such as building the self-esteem of adolescents or reducing the rates of cancer and cardiovascular disease. Most of the programs called for collaboration from various consumer groups, professional organizations, government and nongovernment agencies and, above all, the "target groups" themselves.

Marie Fortier, director-general of the Health Services Directorate at Health and Welfare, told participants that the process of getting people, professions and

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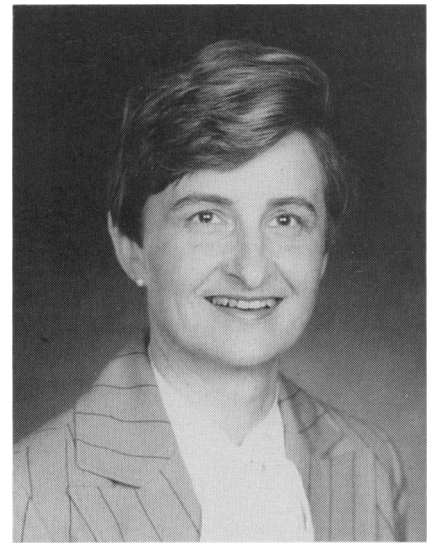
agencies together to carry out useful preventive programs may seem complex, but it has only two fundamental principles: multisectoral collaboration and mutual aid, which is stimulated when communities are empowered to improve their own health. As such, the collaboration process will play a vital role in achieving the principles outlined in the document *Achieving Health for All* because it will help to reduce inequities and emphasize prevention.

The projects discussed at the workshop are probably typical of those that will be developed in the next 10 years, and represent social engineering on an increasingly large scale. Professionals, volunteer groups and government agencies will have to develop new social skills to deal with each other. As Patricia Vertinsky, associate dean in the Faculty of Education at the University of British Columbia, put it: "Collaboration at times appears antithetical to the professional ethic. The professional vocabulary can be very limited. However, in the last analysis the effectiveness of the interventions will be relative to the quality of the [interpersonal] interactions."

In her keynote address Alice Baumgart, president of the Canadian Nurses Association, said it would be foolish to ignore the medical profession when planning any new health care program. "Turf wars" between physicians and nurses are inevitable, she said, because their areas of expertise and commitment overlap. For example, nurses "do assessment" and physicians "make diagnoses." Yet a creative partnership is also possible because there is an overlap. From her perspective, physicians' lack of training in preventive medicine and the medical profession's authoritarian style are potential obstacles to collaboration. In the hospital setting, at least, everyone is expected to carry out "the doctor's orders."



Baumgart: turf wars inevitable

Another problem with the medical style is that preventive activities are often initiated by health care providers, whereas clinical consultation is always initiated by or on behalf of patients. Physicians who switch from reactive to proactive styles in prevention will find it logical to extend their activities into the community and play an advocacy role in contributing to healthy public policy.

In the workshop sessions there was more discussion of the familiar roles of health care providers than of the still largely untried methods of activating communities and getting them involved in coping with health-related problems. Nevertheless, Baumgart pointed out that the traditional approaches to prevention were suited only to the relatively high-income groups — informing and motivating the disadvantaged is an indirect process. Overcoming illiteracy and severe economic disadvantage may be prerequisites to their wanting to adopt healthier lifestyles. As one physician put it: "We have to overcome disease before we can conquer it."

At times most participants became edgy about the new vocabulary: collaborating, coping, enhancing, stakeholders and so forth. Some were also concerned that global objectives promulgated from above would not fit into or be accepted by many communities. As one participant put it: "Sergeant Preston's Law of the North states that the scenery changes only for the lead dog."

Jane Fulton, a professor in the University of Ottawa's Faculty of Health Administration, urged an approach to health promotion and health advocacy that seemed to diverge from the fixation on central planning. In an after-dinner speech she recommended: "Begin where you live. Pay your dues. Do interorganizational work. Form new partnerships."

Once firmly established, she suggested, the activist can influence public policy through advocacy advertising and even personal representation. Finally, there's lobbying for health. There are two kinds: process lobbying, which involves continuous negotiation over a long time, and outcome lobbying, which takes advantage of the "estrus" that consumes politicians about a year before elections.

Collaborating for improved community health is not really new; the great public health advances of the first part of this century were achieved by numerous professions acting in response to obvious needs. Most of the sanitation and infectious disease control problems were not conceptually complex and the starting points for action were well defined.

What is new today is the recognition that the collaboration process has to be made more explicit to recruit and harness the power of the people and agencies that can tackle multidimensional health problems.

We cannot expect rapid results in dealing with widespread, chronic challenges. As one rapporteur said in reference to a program to reduce gas-sniffing in the North: "It's slow as hell, but it works."■